WISCONSIN MEDICAID
PERSONAL CARE SCREENING TOOL (PCST)

Instructions: Print or type clearly. Refer to the Personal Care Screening Tool (PCST) Completion Instructions, HCF 11133A, for information on completing this form.

SCREENING INFORMATION

1. Name — Screening Agency	2. Screen Completion Date
3. Name — Screener	

APPLICANT INFORMATION

4. Name — Applicant (Last, First, Middle Initial)

5. Gender — Applicant ❑ Male ❑ Female	6. Social Security Number — Applicant
7. Address — Applicant (Street, City, State, Zip Code)	8. Date of Birth — Applicant
	9. Telephone Number — Applicant (Optional)
10. County / Tribe of Residence — Applicant	11. County / Tribe of Responsibility — Applicant

12. Directions (Optional)

13. Medical Insurance

Check all that apply.

- ❑ Medicare (Specify Identification Number) _____.
  - ❑ Part A Effective Date (If Known) _____.
  - ❑ Part B Effective Date (If Known) _____.
  - ❑ Medicare Managed Care.
- ❑ Medicaid (Specify Recipient Identification Number) _____.
- ❑ Private Insurance (Includes Employer-Sponsored [Job Benefit] Insurance).
- ❑ Private Long Term Care (LTC) Number.
- ❑ Railroad Retirement (Specify Number) _____.
- ❑ Other Insurance.
- ❑ No medical insurance at this time.

Continued

APPLICANT INFORMATION (Continued)

14. Race (Optional)

Check all boxes that apply.

❑ Black or African American ❑ Asian or Pacific Islander
❑ White ❑ American Indian or Alaskan Native
❑ Other _____

15. Ethnicity (Optional)

❑ Spanish / Hispanic / Latino

16. Interpreter Services (Optional)

Is an interpreter required? ❑ Yes ❑ No

If so, in what language?

❑ 01 American Sign Language ❑ 04 Hmong ❑ 07 A Native American Language
❑ 02 Spanish ❑ 05 Russian
❑ 03 Vietnamese ❑ 06 Other _____

17. Responsible Party Contact Type (Optional)

❑ Adult Child ❑ Power of Attorney
❑ Ex-spouse ❑ Sibling
❑ Guardian of Person ❑ Spouse
❑ Other Parent / Stepparent ❑ Other Informal Caregiver / Support _____

18. Name — Responsible Party (Last, First, Middle Initial) (Optional)

19. Telephone Number — Responsible Party (Optional)

20. Address — Responsible Party (Street, City, State, Zip Code) (Optional)

21. Comments (Optional)

22. Scheduled Activities Outside Residence (Include a schedule of activities in the applicant's medical file.)

Does the applicant attend scheduled activities outside the residence? ❑ Yes ❑ No

If yes, how many days per week do regularly scheduled activities occur? _____

23. Diagnosis Codes

List up to three *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes that most directly relate to the applicant's need for home care. At least one ICD-9-CM code is required.

ICD-9-CM Code 1_____

ICD-9-CM Code 2_____

ICD-9-CM Code 3_____

Continued

APPLICANT INFORMATION (Continued)

24. Living Situation (Indicate where the applicant currently lives.)

Own Home or Apartment
- ❑ Alone. (Includes person living alone who receives in-home services.)
- ❑ With Spouse / Partner / Family.
- ❑ With Nonrelative / Roommates.
- ❑ With Live-in Paid Caregiver(s). (Includes service in exchange for room and board.)

Someone Else's Home or Apartment
- ❑ Family.
- ❑ Nonrelative.
- ❑ Paid Caregiver's Home (e.g., one to two-bed adult family home or child foster care).
- ❑ Home / Apartment for Which Lease Is Held by Support Services Provider.

Apartment with Services
- ❑ Residential Care Apartment Complex.
- ❑ Independent Apartment Community-Based Residential Facility (CBRF).

Group Residential Care Setting
- ❑ Licensed Adult Family Home (three to four-bed home).
- ❑ Community-Based Residential Facility with 1-20 Beds.
- ❑ Community-Based Residential Facility with More than 20 Beds.
- ❑ Children's Group Home.

Health Care Facility / Institution
- ❑ Nursing Home.
- ❑ Intermediate Care Facility for Mental Retardation (ICF-MR/FDD).
- ❑ Developmental Disability Center / State Institution for Developmental Disabilities.
- ❑ Mental Health Institute / State Psychiatric Institution.
- ❑ Other Institution for Mental Disease.
- ❑ Child Caring Institution.
- ❑ No Permanent Residence (e.g., a homeless shelter).

Other
- ❑ Specify (e.g., jail). _____

ACTIVITIES OF DAILY LIVING

25. Bathing

"Bathing" means the ability to wash the entire body (excludes grooming, washing hands and face only, and bathing related to incontinence care) with shower, tub, sponge, or bed bath for the purpose of maintaining adequate hygiene. This includes the ability to get in and out of the tub or shower, turning faucets on and off, regulating water temperature, wetting, soaping, and rinsing skin, shampooing hair, drying body, and applying lotion to skin. Bathing includes all transfers and mobility related to bathing.

Select the response, A-F, that best describes the level of function the applicant possesses when bathing.

- ❑ A. Applicant is able to bathe him or her self in the shower or tub with or without an assistive device.
- ❑ B. Applicant is able to bathe him or her self in the shower or tub but requires presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to bathe him or her self in shower or tub but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant is able to bathe in shower, tub, or bed with partial physical assistance from another person.
- ❑ E. Applicant is unable to effectively participate in bathing and is totally bathed by another person.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate how many days per week personal care worker (PCW) assistance is needed with bathing. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

26. Dressing

"Dressing" means the ability to dress and undress (with or without an assistive device) as necessary and choose appropriate clothing. This includes the ability to put on prostheses, braces, splints, and/or anti-embolism hose (e.g., "TED" stockings), and includes fine motor coordination for buttons and zippers. Difficulties with a zipper or buttons **at the back** of a dress or blouse do not constitute a functional deficit. Dressing also includes all transfers and mobility related to dressing and undressing.

Upper Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her upper body.

- ❑ A. Applicant is able to dress upper body without assistance or is able to dress him or her self if clothing is laid out or handed to the person.
- ❑ B. Applicant is able to dress upper body by him or her self but requires presence of another person intermittently for supervision of cueing.
- ❑ C. Applicant is able to dress upper body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs partial physical assistance from another person to dress upper body.
- ❑ E. Applicant depends entirely upon another person to dress upper body.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate whether or not PCW assistance is needed with placement and removal of an upper body prosthetic, splint, or brace.

❑ Yes ❑ No

Indicate when PCW assistance with dressing the upper body is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the upper body. _____

Comments _____

Lower Body
Select the response, A-F, that best describes the level of function the applicant possesses when dressing his or her lower body.

- ❑ A. Applicant is able to dress lower body without assistance or is able to dress him or her self if clothing is laid out or handed to the person.
- ❑ B. Applicant is able to dress lower body by him or her self but requires presence of another person intermittently for supervision of cueing.
- ❑ C. Applicant is able to dress lower body by him or her self but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs partial physical assistance from another person to dress lower body.
- ❑ E. Applicant depends entirely upon another person to dress lower body.
- ❑ F. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate whether or not PCW assistance is needed with placement and removal of a lower body prosthetic, splint, or brace.

❑ Yes ❑ No

Indicate when PCW assistance with dressing the lower body is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the lower body. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

27. Grooming

"Grooming" means the ability to tend to personal hygiene needs (i.e., washing face and hands, combing or brushing hair, shaving, nail care, applying deodorant, oral or denture care, eyeglass care [including contact lenses], and hearing aid assistance). Grooming includes all transfers and mobility related to grooming.

Select the response, A-G, that best describes the level of function the applicant possesses when grooming.

- ❑ A. Applicant is able to groom him or her self, with or without the use of assistive devices or adapted methods.
- ❑ B. Applicant is able to groom him or her self but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to groom him or her self but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs physical assistance to set up grooming supplies but can groom him or her self.
- ❑ E. Applicant needs partial physical assistance to groom him or her self.
- ❑ F. Applicant depends entirely upon another person for grooming.
- ❑ G. Applicant's ability is age appropriate for a child age 5 or younger.

Indicate when PCW assistance with grooming is needed.

❑ AM ❑ PM ❑ Both

Indicate how many days per week PCW assistance is needed with dressing the upper body. _____

Comments _____

28. Eating

"Eating" means the ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food.

Select the response, 0 or A-H, that best describes the level of function the applicant possesses when eating. If both responses "D" and "E" apply, select response "E".

- ❑ 0. Applicant is fed exclusively via tube feedings or intravenously.
- ❑ A. Applicant is able to feed him or her self, with or without use of assistive device or adapted methods.
- ❑ B. Applicant is able to feed him or her self but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to feed him or her self but requires the presence of another person throughout the task for constant supervision to ensure completion of the task.
- ❑ D. Applicant needs physical assistance at meal time to cut meat, arrange food, butter bread, etc.
- ❑ E. Applicant has recent history of choking or potential for choking based on documentation.
- ❑ F. Applicant needs partial physical feeding from another person.
- ❑ G. Applicant needs total feeding from another person.
- ❑ H. Applicant's ability is age appropriate for a child age 3 or younger.

Indicate the meals for which PCW assistance is needed.

❑ Breakfast ❑ Lunch ❑ Dinner

Indicate how many days per week PCW assistance is needed for each meal.

Breakfast _____ Lunch _____ Dinner _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

29. Mobility in the Home

"Mobility in the home" means the ability to move between locations in the applicant's living environment, including the kitchen, living room, bathroom, and sleeping area. **This excludes basements, attics, yards, and any equipment used outside the home.** This category excludes mobility related to bathing, dressing, grooming, and toileting.

Select the response, 0 or A-F, that best describes the level of function the applicant possesses when moving between locations in the home.

- ❑ 0. Applicant remains bedfast.
- ❑ A. Applicant is able to ambulate by him or her self, with or without an assistive device.
- ❑ B. Applicant is able to ambulate by him or her self, with or without assistive device but requires presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to ambulate by him or her self, with or without assistive device but requires presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of task.
- ❑ D. Applicant needs the physical help of another person to negotiate stairs or home ramp within the applicant's living environment.
- ❑ E. Applicant needs constant physical help from another person. (Includes total dependence with moving wheelchair.)
- ❑ F. Applicant's ability is age appropriate for a child 18 months or younger.

Indicate how many days per week PCW assistance is needed with mobility in the home. _____

Comments _____

30. Toileting

Toileting includes transferring on and off the toilet, cleansing of self, changing of personal hygiene product, emptying an ostomy or catheter bag, and adjusting clothes. Toileting includes all transfers and mobility related to toileting.

Select the responses, A-G, that best describe the level of function the applicant possesses when toileting. **Select all options that apply.** Both options "C" and "D" should be selected if the applicant is toileted and is incontinent. If options "C," "D," "E," or "F" are selected, also include the frequency of the situation described.

- ❑ A. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device.
- ❑ B. Applicant is able to toilet him or her self or provide his or her own incontinence care, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to toilet him or her self or provide his or her own incontinence care but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ D. Applicant needs physical help from another person to use toilet and/or change personal hygiene product.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ E. Applicant needs physical help from another person for incontinence care. (Does not include stress incontinence.)

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ F. Applicant needs physical help from another person to empty ostomy or catheter bag.

  Estimate frequency per day that PCW assistance is needed with toileting. _____
- ❑ G. Applicant's ability is age appropriate for a child age 4 or younger.

Indicate how many days per week PCW assistance is needed for toileting. _____

Comments _____

Continued

ACTIVITIES OF DAILY LIVING (Continued)

31. Transferring

"Transferring" means the physical ability to move between surfaces (e.g., from bed/chair to wheelchair or walker), the ability to get in and out of bed or usual sleeping place, and the ability to use assistive devices for transfers. Transferring excludes transfers related to bathing, dressing, grooming, and toileting.

Select the response, A-F, that best describes the level of function the applicant possesses when transferring.

- ❑ A. Applicant is able to transfer him or her self, with or without an assistive device.
- ❑ B. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person intermittently for supervision or cueing.
- ❑ C. Applicant is able to transfer him or her self, with or without an assistive device but requires the presence of another person throughout the task for constant supervision to provide immediate intervention to ensure completion of the task.
- ❑ D. Applicant needs physical help of another person but is able to participate (e.g., applicant can stand and bear weight).
- ❑ E. Applicant needs constant physical help from another person and is unable to participate (e.g., applicant is unable to stand and pivot or unable to bear weight).
- ❑ F. Applicant needs help from another person with the use of a mechanical lift (e.g., Hoyer) when transferring.
- ❑ G. Applicant's ability is age appropriate for a child age 3 or younger.

Indicate how many days per week PCW assistance is needed with transferring. _____

Comments _____

MEDICALLY ORIENTED TASKS

32. (**Part I**) Medication Assistance

Select the appropriate response.

- ❑ 0. Not applicable.
- ❑ A. Independent with medications with or without the use of a device.
- ❑ B. Needs reminders.
- ❑ C. Needs the physical help of another person.
- ❑ D. Needs the physical help of a PCW.

  Frequency per day. _____

Indicate how many days per week PCW assistance is needed with medication assistance. _____

Comments _____

33. (**Part II**) Tasks to be Performed by a PCW

Select the tasks to be completed by a PCW. Indicate the frequency per day and days per week each task will be performed.

- ❑ Glucometer Readings (Allowed when medical history supports the need for frequent ongoing monitoring and the physician has established parameters.)
  PCW Frequency Per Day _____ PCW Days Per Week _____

- ❑ Vital Signs (Allowed when medical history supports the need for frequent ongoing monitoring and the physician has established parameters.)
  PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

33. (**Part II**) Tasks to be Performed by a PCW (Continued)

❑ Skin Care (Application of prescription ointments.)

Name of prescription medication _____

Frequency prescribed _____

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Catheter Site Care

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Gastrointestinal Tube Site Care

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Complex Positioning

PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

34. (**Part III**) Tasks to Be Performed by a PCW **—** Medicaid Review and Manual Approval May Be Required

Select the tasks to be completed by a PCW as delegated by the registered nurse. Indicate the frequency per day and days per week each task will be performed. For tasks indicated in this element, manual review of the prior authorization (PA) request will be required only when the total amount of time computed by the PCST is insufficient for a PCW also to provide the delegated medical tasks identified in this element *and* additional time is being requested for those delegated medical tasks. Include the Personal Care Addendum, HCF 11136, (include the recipient's plan of care) and other documentation as directed when submitting the PA request.

Daily Tube Feedings (Nasogastric or Gastrostomy)

❑ Continuous Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Intermittent (Bolus) Feeding PCW Frequency Per Day _____ PCW Days Per Week _____

Respiratory Assistance (Check all that Apply.)

❑ Tracheostomy Care PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Suctioning PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Chest Physiotherapy (CPT) PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Nebulizer PCW Frequency Per Day _____ PCW Days Per Week _____

Bowel Program (Check all that Apply.)

❑ Suppository PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Enema PCW Frequency Per Day _____ PCW Days Per Week _____

❑ Digital Stimulation PCW Frequency Per Day _____ PCW Days Per Week _____

Continued

MEDICALLY ORIENTED TASKS (Continued)

34. (**Part III**) Tasks to Be Performed by a PCW **—** Medicaid Review and Manual Approval May Be Required (Continued)

Other Program (Check all that apply.)

❑ **Wound or Decubiti Care (Excludes Basic Skin Care)** PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Therapy Program (Therapy plan prescribed by a physical therapist, occupational therapist, or speech-language pathologist within the last 12 month period.)**

PCW Frequency Per Day _____ PCW Days Per Week _____

❑ **Other (Specify all tasks that apply.)**

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

_____ PCW Frequency Per Day _____ PCW Days Per Week _____

Comments _____

INCIDENTAL SERVICES

35. Will services incidental to the activities of daily living (ADL) and medically oriented tasks be performed by the PCW?

Incidental services include changing the applicant's bed, cleaning medical equipment, laundering the applicant's bed linens and personal clothing, light cleaning in essential areas of the home used during personal care services, purchasing food, preparing the applicant's meals, and cleaning the applicant's dishes. (Refer to the Covered Services Section of the Personal Care Handbook.)

❑ Yes ❑ No

BEHAVIORS AND MEDICAL CONDITIONS

36. Behaviors

Does the applicant exhibit behavior that makes ADL tasks more difficult for a PCW to complete?

❑ Yes ❑ No

If "Yes," list the behavior(s).

37. Medical Conditions

Does the applicant have any medical conditions that make ADL tasks more difficult for a PCW to complete?

❑ Yes ❑ No

If "Yes," list the medical condition(s) (e.g., severe contractures, hemiplegia, severe shortness of breath) and describe how the condition(s) makes the ADL tasks more difficult for the PCW to complete.

Continued

BEHAVIORS AND MEDICAL CONDITIONS (Continued)

38. Seizures

Does the applicant have a diagnosis of seizures? ❑ Yes ❑ No

If "Yes," complete the following.

Date of last seizure was

- ❑ A. 0-90 days ago.
- ❑ B. 91-180 days ago.
- ❑ C. more than 180 days ago.

Specific Seizure Type _____

Frequency of Seizures _____

Date of Last Seizure _____

Does PCW provide interventions? ❑ Yes ❑ No

If "Yes," list interventions.

MEDICAL APPOINTMENTS

39. Accompanying Applicant to Medical Appointments

Does a PCW need to accompany the applicant to medical appointments?

❑ Yes ❑ No

BILLING PROVIDER INFORMATION

40. Name — Billing Provider	41. Billing Provider's Medicaid Provider Number

42. Address — Billing Provider (Street, City, State, Zip Code)

SIGNATURE

As the authorized screener completing this PCST, I confirm the following: All information entered on this form is complete and accurate, and I am familiar with all of the information entered on this form.

43. **SIGNATURE** — Authorized Screener	44. Date Signed — Authorized Screener